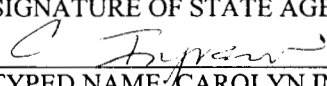



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 04-011	2. STATE New Mexico
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 12/01/04 10/01/04 *	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1924 of the Act 435.725 435.733 435.832		7. FEDERAL BUDGET IMPACT: a. FFY 05 \$ 140,000. b. FFY 06 \$ 336,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.6-A Page 4a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.6-A Page 4a	
10. SUBJECT OF AMENDMENT: Update of Personal Needs Allowance used in the post eligibility calculation for individuals and couples in a nursing facility.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Director, Medical Assistance Division <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Carolyn Ingram, Director NM Medical Assistance Division P.O. Box 2348 - ARK Bldg. Santa Fe, NM 87504-2348	
13. TYPED NAME: CAROLYN INGRAM			
14. TITLE: Medical Assistance Division Director			
15. DATE SUBMITTED: 10/30/04			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 16 NOVEMBER 04		18. DATE APPROVED: 4 JANUARY 2005	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 OCTOBER 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: ANDREW A. FREDRICKSON		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH	
23. REMARKS: * Per Andy Salway state is requesting effective date of 10/01/04.			

State NEW MEXICO

Citation(s)	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutional care: Personal Needs Allowance (PNA) of not less than \$30 For Individuals and \$60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals \$ <u>52</u> . Couples \$ <u>104</u> .

This amount is adjusted annually based on the CPI.

For the following individuals with greater need:
Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met.

- b. AFDC related:
Children \$ 52
Adults \$ 52

For the following individuals with greater need:
Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the authority for approving that a criterion is met.

- c. Individuals under age 21 covered in this plan as specified in Item B.7. of ATTACHMENT 2.2-A.
\$ 52.

TN No: 04-11 Approval Date 1-4-05
Supersedes
TN No. 00-10

Effective Date 10-1-04

STATE <u>New Mexico</u>	A
DATE REC'D <u>11-16-04</u>	
DATE APPV'D <u>1-4-05</u>	
DATE EFF <u>10-1-04</u>	
HCFA 179 <u>04-11</u>	

Supersedes TN 00-10